THE HAMPDEN HIPPOCRAT
The Hampden District Medical Society Newsletter

SPRING 2008 VOLUME 17

President's Annual Message:

Preparing for Retirement?

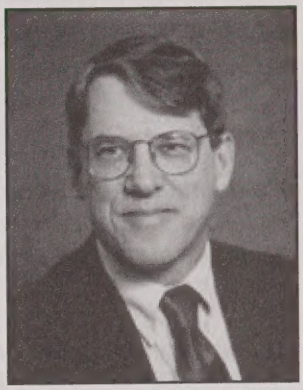
Many people have heard my views on the problem of physician supply in the US. To summarize, we are heading toward a significant physician shortage, one that cannot be averted, one that cannot be prevented by allowing more international medical graduates to enter the US, and one that cannot be cured by training more mid-level providers. It is clear from statistics in the recent "education" issue of JAMA, that there are some increases in the number of matriculating medical students in the US, but the numbers will clearly fail to balance the rapid increase in physician retirees in the next decade.

Having started the earliest thinking and planning about retirement (yes, at age 57, this is appropriate), I am disturbed that no one in the medical care infrastructure seems to care whether a physician leaves clinical practice at age 58 or 70. Somehow, everyone seems to be assuming – that fatal word – that physicians are always going to behave as does the rest of the population, working at full-tilt until age 65 or 66, then leaving the profession.

If one assumes that a surgeon has an approximately 33 or 34 year professional span in the operating room, then to have that doctor leave practice before age 60, which is the dominant case in the US today, means that there is a 10% to 15% lifetime loss of productivity to society at large. If one studies the numbers relative to the provision of surgical care in the US, we cannot afford that loss, especially in more rural environments.

A few years ago, I made a contribution to an AMA publication on Leaving the Bedside, which is no longer available, and that compendium focused heavily on winding down a practice, rather than addressing retirement issues directly. There were examples of ways physicians "morphed" their practices from standard clinical work, but there was little on managing the balance of personal life and work into the years as a senior physician.

Truly remarkable is the fact that hospitals and insurers seem to act as though retirement of physicians does not matter. Their policies are predicated on the assumption that there will always be a replacement physician available to their constituencies. One would think that hospitals, in particular, would find it in their best interest to factor the process of physician aging, illness, need for rest and vacation, and ultimately replacement into their planning. I have yet to hear of a hospital system that has queried a medical staff member about such planning or his/her needs when they have hit the magic age of 55.



Jeffrey L. Kaufman MD, FACS, President 2007-2008

There should be a better retirement planning process in order to protect access to medical care for the community at large. Senior physicians increasingly want to take less on-call coverage responsibility. They want (and deserve!!) to take longer blocks of vacation time, and they are under increasing pressure from spouses to change their work as their "nests" empty. In addition, senior physicians are more likely than their junior colleagues to need time off for medical evaluations and treatments, which means time off during the day. It is amazing how much it can be a problem to obtain that necessary time.

What is evident from the activities of some recent retirees in western Massachusetts is that a significant percentage will formally quit practice, and then return to some clinical activity with a reduced workload. We have congratulated Dr. Stoddard for his "retirement" work with the Shriner's Hospital and for his international cleft palate work. Others have quietly returned to help with medical clinics, with teaching medical students, and as assistants in surgery (with appreciation to Drs. Mouchantat and Hojnoski, to note only two among many others).

Retention of physicians is headed to become a major priority in the next decade. Our peers and our institutions should be tracking the retirement plans of colleagues. Malpractice insurance premiums for these providers should not be a hindrance to their continued work on a part-time basis. A physician who is willing to work part-time should be cherished for his or her contributions, especially if that work assists patients with the fewest resources.

Sincerely,

Jeffrey L. Kaufman MD, FACS

President 2007-2008

LETTER POLICY

The "Hampden Hippocrat Newsletter" is the news media of the Hampden District Medical Society and would like to become the forum for sharing information and opinions amongst the members, for whom it is being created. Any article printed expresses the opinion of the author and should not be construed to imply endorsement by the Society.

Letters to the editor should be approximately 250 words or less, preferably typed in Word and sent to hdms@massmed.org or, fax to (413) 731-8990. Please provide the full name and address of the writer. All letters are subject to editing. Please note, the Editor is not responsible for typos and if any corrections are needed, they will appear in the following Newsletter.

Or you may mail your article to: The Hampden Hippocrat
1111 Elm Street, Suite 22 West Springfield, MA 01089-1540

MANAGING EDITOR
Suzanne Skibinski, Executive Director

SOME THINGS JUST NEVER CHANGE

Previously published in 1982 by the Honolulu County Medical Society

To members of Hampden District Medical Society

After you have read this issue of the Hampden Hippocrat and the following article, please pass it on to a non-member.

TO JOIN OR NOT TO JOIN, THAT IS THE QUESTION!

Your medical society operates in the business and economic world just as you do. The people and things needed to provide the kinds of services to you as a profession and to the public cost money. Salaries, supplies, and space, for example, are operational costs you must bear. But if more physicians would join, these costs would be spread over a larger group, and the dollar impact would not be as great on the individual physician

"THE SOCIETY DOESN'T REPRESENT ME!"

No two people agree on everything all of the time. Physicians, like most other people, often only dwell on the "disagreements" and "differences of opinion" that exist between themselves and other physicians. Look at the issues and concerns we do agree on – there are many if you stop to think about it. Let's work to expand this common ground of agreement from within the society or association. Together we can improve patient care and benefit the entire medical profession.

"ONLY A SMALL CLIQUE OF PHYSICIANS RUN THE SOCIETY"

(i.e.: The same people are elected...a newcomer with ideas differing from those of the current leadership stands little chance of breaking into the "inner circle.")

You-the membership itself – elect the leaders of your society directly, in the county societies, or indirectly, through your elected delegates. The medical society has always followed the democratic principle, "majority rules." Your voice cannot be heard if you stand apart and criticize organized medicine. If there are changes to be made, join the organization, enlist the support of other members, and work toward those changes.

"THE SOCIETY DOESN'T DO ANYTHING FOR ME"

The society works for the benefit of the entire profession, **YOU BENEFIT** when we push for seat belt safety, conduct peer review, testify some 40 times each year on legislation affecting your ability to practice medicine, and contribute 50,000 volunteer physician man-hours each year to review, discuss, debate, investigate, and implement the many health issues, concerns and programs in this community.

"I'M JUST NOT A JOINER!"

It's nice to be individualist – but, realistically, in today's world, there has to be some organized body pushing and fostering the legitimate interests of any profession. Whether you join out of professional responsibility – whether you join out of curiosity – whether you join out of anger at what exists – whether you join out of the need for protection – the issue of "joining" because you **ARE** or **ARE NOT** A "JOINER" IS REALLY MOOT.

ODE TO THE MEMBERSHIP

Some say we've been members many years
Let the new ones do the work.
We will keep our membership.
But committee work we'll shirk.
Let's function as we should
All working for common ends.
Sure, there will be frustrations
But let us not get the bends.
Let's pull together towards our goals
Solidarity means a lot.
And if some of our goals are thwarted
We'll have many others which are not.

By: Carl Janovsky, M.D.
Chair 1982-83 Membership Committees

If you want to work on behalf of your local medical society, please contact Suzanne Skibinski, Executive Director at (413) 736-0661

MEMBER BENEFIT

As a member of the Society you have access to the Massachusetts Medical Society's Physician Practice Resource Center. The Center continues to expand its role by providing new tools for practices that will answer the needs of physicians in the state of Massachusetts.

The newest addition is the EHR Cost Calculator. This tool is a spreadsheet that allows practices to comprehensively work through the expenses associated with Information Technology and Electronic Health Records. The various components, hardware and software, are listed and linked to formulas and definitions to assist in determining the impact of an IT implementation. There is also space provided to define the impact of the adoption on staff and physicians.

Starting in February, the PPRC published a quarterly newsletter of Practice Management information, covering topics including compliance issues, IT issues, and financial and operational issues. We are working with some of the most knowledgeable experts who will be offering their thoughts on these complex issues.

The practice management consultant, Adam Shlager, is available to discuss the resources as well as answer any other practice management questions.

The Massachusetts Medical Society offers comprehensive Practice Management Consulting services through the Physician Practice Resource Center at a member-discounted rate.

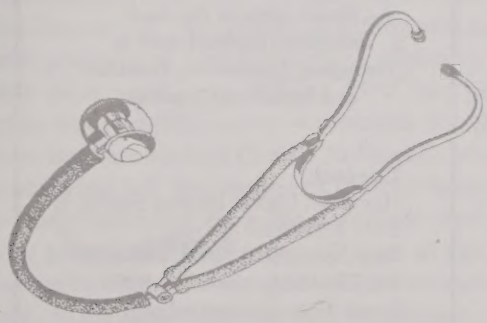
Website: www.massmed.org/pages/pprc.asp. You may also e-mail the PPRC at pprc@massmed.org, or call (781) 434-7702 or 800-322-2303, ext. 7702.Services can be accessed by calling 781-434-7702, or e-mailing ashlager@mms.org,

Jantoven, A new trade name for Warfarin

For decades, in the US, we have had brand-named warfarin under the name Coumadin. Now, there is a competing product, really another generic drug, under the name Jantoven. Already, we have had medication reconciliation errors in our office over this new name for an old drug. All practitioners should recognize that Jantoven is, indeed, an anticoagulant, with appropriate precautions for its administration.

If other HDMS members have similar concerns about other drugs that come forth, please send a note to the society, and we will publish it.

JLKaufman, M.D.



Health Care in Massachusetts

Key Indicators is a new quarterly report by the Division of Heath Care Finance and Policy. Key Indicators provides an overview of the Massachusetts health care landscape through data reported by providers, health plans, government, and through surveys of Massachusetts residents and employers.

The report reviews the progress of statewide efforts to expand health insurance coverage, the financial performance of hospitals, community health centers and health plans, health insurance costs, and consumer access to health care. These indicators provide an important framework for measuring our progress as we continue implementation of health reform in 2008.

NPI

- On March 1, 2008, physicians billing Medicare were no longer permitted to submit paper and electronic claims using just their old, or legacy, provider number. All Medicare claims were to include just the physician's NPI or the physician's NPI plus his or her legacy number.
- On May 23, 2008, physicians are required to use only their NPI on all electronic claims to public and commercial payers. No legacy numbers will be permitted on any electronic claims or any Medicare paper claims.
- The AMA advises physicians and their office staff members to check for NPI informational warnings on pre-pass reject reports from CMS to billing agents and to work closely with their clearinghouse or billing agent to fix future claims.
- Insure that your claims process correctly. If rejected, go to https://nppes.cms.hhs.gov or call (800) 465-3203 to ensure that your correct legacy number appears in the "Other Provider Identification Numbers" field in the NPI system. If the information in the NPI system is correct, contact your contractor and ask to validate what appears in its system.

Physician Workforce Study

The Massachusetts Medical Society's sixth annual physician work force study recently found that while recruiting of new doctors can be difficult, it is more pronounced in Western Massachusetts than in greater Boston and in the face of implementation of the state's landmark health-care reform law that requires that every adult have insurance, there are now concerns there aren't enough doctors to go around.

Statewide, there are too few doctors, and severe or critical shortages exist in a number of specialties, including anesthesiology, cardiology, gastroenterology, neurosurgery, psychiatry, urology and vascular surgery.

New legislation that would create a loan forgiveness program for primary care physician has advanced out of the Joint Committee on Health Care Financing.

Can Comprehensive Health Care Reform Efforts Work?

In April 2006, Massachusetts became the first state in the country to enact a law requiring its residents to carry health insurance. Since its inception, the Massachusetts Health Care Reform Plan has dramatically reduced the number of uninsured residents in the state, cutting the state's uninsured rate to about 5 percent by bringing more than 300,000 previously uninsured people into the health care system.

The health care plan has created a growing demand for primary health care services that cannot be met with the state's existing supply of primary care physicians, according to state officials.

Without an adequate supply of primary care physicians, the plan cannot guarantee timely access to care, creating a gap between coverage and actual provision of services. As a result, waiting times to see a primary care physician can amount to weeks and even months in some instances.

With a primary care shortage, many patients have to turn to sub-specialists for their primary care needs, leading, in turn, to increases in health care costs while undermining the true intent of the Massachusetts Health Care Reform Plan.

Legislators recognize the importance of primary care and that more needs to be done to promote primary care and to convince students and residents to enter the primary care field.

Senator Richard Moore and Massachusetts Senate President Therese Murray introduced a bill to make primary care a more attractive practice option for physicians. The bill provides payment increases for primary care physicians, while creating a loan forgiveness program for residents who agree to become primary care physicians and practice in parts of the state with the least access to primary care services.

- In a recent "Letter to the Editor" column in The Republican, a writer wrote that recently the company that she worked for moved out of the country and exhausted her severance pay including insurance.

  Now on unemployment benefits she is forced to take an insurance plan with a monthly premium that isn't affordable because of making too much on unemployment. And, after treating with the same doctor for several years the doctor doesn't take the new insurance plan. However, if she was eligible for MassHealth she would have been able to remain a patient. The question being is, someone is forced by the government to take this plan why shouldn't the doctor be forced to accept it?

- An editorial in the same newspaper stated that a report from the Massachusetts Hospital Association said that there is a sharp drop in the number of people seeking free care in the ED-a goal of the state's landmark health-care reform law-evidence the measure is succeeding.

  The new report found that the decline in requests for free care to hospitals from fiscal year 2006 to fiscal year 2007 was 7.5 percent statewide, primarily because of steep declines in Boston and Western Massachusetts, a 17 percent drop and a 14 percent drop respectively.

Specific numbers relating to free care costs were not available.

If the approximately 8 percent of the population without health insurance were to receive national insurance coverage, the demand for health care services and for additional health personnel would increase by roughly the same percentage.

"In view of existing shortages, such an increase would place a tremendous strain on the health system and on educational institutions to produce the additional workforce needed in a short period of time.
The potential workforce effects of maintaining the status quo or focusing on cutting costs by shifting health care services to lower-paid providers.)
AMA news 2-6-08

Western Massachusetts Host for Legislative Hearings on Women's Health

Hampden members, Drs. Ronald Burkman, Stephen Metz, Sherry Taylor and James Wang were part of a blue-ribbon panel that convened at Western New England College to discuss the crisis in shortages of doctors in Western Massachusetts.

The "Hearing" on January 30, 2008 focused on key shortages at an alarming rate, the loss of doctors in the region who specialize in obstetrics, gynecology and the neurosurgical care of women.

In Western Massachusetts it has become increasingly difficult to get suitable candidates" to interview for a job and, in a recent survey done by the district medical society, several doctors in Western Massachusetts are not taking new patients. In some practices doctors' are seeing between 3,000 and 4,000 patients and, the wait to see another doctor taking new patients is several months.

The average medical school debt is $200,000, and data shows the median income for primary-care physicians in Western Mass is $150,000.

A state Department of Public Health survey found that from 2002 to 2004, 16 percent of the obstetricians, nurse midwifes and family practitioners were lost in the four western counties, compared to an 8.6 percent loss in the state as a whole. The federal government has determined that nearly two-thirds of the four western counties, including all of Hampden, Franklin and Berkshire counties are now "medically underserved."

The 14 member commission, created by the Legislature and chaired by state Public Health Commissioner John Auerbach is charged with examining the quality and accessibility of doctors in the region who specialize in obstetric, gynecological and neurosurgical care.

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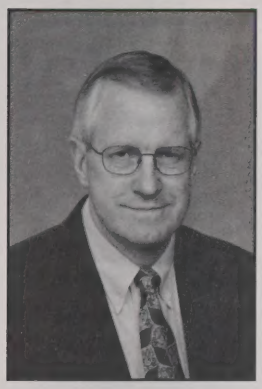

Commission on Public Health Access for Obstetrics & Gynecology & Neurosurgery in Western Massachusetts

Ronald T. Burkman, MD

I wish to thank the Commission for allowing me to testify today. My name is Dr. Ronald Burkman. I am an attending obstetrician-gynecologist at Baystate Medical Center. Previously, I served as the Chairman of the Department of Obstetrics & Gynecology from 1995 through April 2007 and am still very active within the department. I have also served as the Chair of the Massachusetts Section of the American College of Obstetricians and Gynecologists and continue to serve on its Legislative Committee.

My testimony will focus on the difficulties faced in maintaining a critical mass of obstetrician-gynecologists within the Pioneer Valley as well as the rest of Western Massachusetts; a problem which affects quality as well as access to care.

Within Baystate Health's system, there are currently two obstetrician-gynecologists at Mary Lane, two at Franklin Medical Center with another one being recruited for the fall of 2008, while at Baystate Medical Center, the only academic tertiary care hospital in the area, there are four maternal-fetal medicine specialists, one gynecologic oncologist specialist, 4 reproductive endocrinologists (two are part time), two urogynecologists, no perinatal geneticists, and 36 generalists. Among the generalists, approximately one third work part-time and at least six have given up the practice of obstetrics.

The area that Baystate Health serves is clearly economically challenged compared to many areas of the state which results in a poor payor mix for many of the practitioners, yet the practitioners face the same expenses that others within the state do such as costs for support staff, general overhead, and malpractice insurance premiums. In essence, only the cost of housing or office space is lower than in Boston; the other expenses are equivalent. In this region, there is a mix of rural communities, small towns, and one urban center. It is an area that is culturally diverse comprising of Latinas, Russians, Somali's, many of whom are high risk as it relates to obstetrics and many who present challenges from the standpoint of providing translation services and support services such as nutrition and social services.

During my tenure as a chair, as well as a practitioner at Baystate Medical Center, I have faced a number of challenges as it relates to recruiting. For example, Mary Lane Hospital was without obstetrician-gynecologists for over two years requiring staffing with locum tenums as well as with practitioners from Springfield. However, the patients, many of them poor, were disadvantaged for a long period by the requirement to travel approximately 45 minutes for obstetrical or surgical care at Baystate Medical Center. At Franklin Medical Center this past summer and fall, the number of obstetrician-gynecologists declined to one practitioner, requiring physicians from Springfield as well as one practitioner who is over 70 years of age recruited to provide coverage for obstetrical and gynecologic care during the nights and weekends. In the area of sub-specialty recruitment, we have had one gynecologic oncologist for the past two to three years. Further, at one time, we were down to half the current component of high-risk maternal-fetal medicine specialists; it also took two to three years to bring them up to full strength. Finally, we recently lost our only perinatal geneticist to an industry.

A number of other areas within the general area of the Pioneer Valley also continue to be poorly served. To my knowledge, I am the only obstetrician-gynecologist who provides services within Palmer and this is only for one day a week. Currently, there is only one obstetrician-gynecologist who provides services on a full-time basis in Westfield. This degree of staffing affects not only access to care but also patient safety.

From the standpoint of recruitment of new obstetrician-gynecologists, it is important to recognize there have been some substantial demographic changes. Currently, 70% of the individuals entering the specialty are women. However, as they complete their training, they have many personal challenges. Many have ever-increasing medical school debt (about $130,000 on average) as well as challenges relative to the balance of work with a desire to start a family. Further, a generation clearly views this balance to be crucial for their well-being. Therefore, they are far less willing to work within practices that require excessive daytime work hours for on-call coverage that is every other night or every third night... They also recognize that excess work hours significantly affect patient safety. Thus, the ability to recruit many of these individuals to practices with small numbers of providers is exceedingly difficult.

In summary, the ability to recruit adequate numbers of obstetrician-gynecologists to this area faces the challenges of high practice expense especially malpractice insurance, a poor payer mix in many instances compared to other area of the state which especially affects reimbursement for gynecologic and preventive services, culturally diverse and high-risk patients who require other services which are difficult to provide, and practices that can often times not compete with larger group practices in urban areas.

There are several potential approaches, which the Commission may wish to consider which may make this area more attractive for the recruitment of obstetrician- gynecologists. Many of the smaller group practices within the area cannot afford the cost of hiring a full-time physician although there may be enough work for a part-time practitioner... At the same time, some obstetrician-gynecologists may wish to only work part-time. However, currently there is no malpractice insurance available that reduces the cost for part-time practitioners. The Commission may consider some type of approach, which could influence malpractice carriers to provide reduce rate coverage for part-time practitioners. Although attempts to directly deal with tort reform have been largely unsuccessful over the past several years, other approaches such as removing the risk associated with apologies to patients and requiring expert witnesses to be board certified in the field in which they are testifying, will at least show obstetrician-gynecologists that there is at least some attempt to improve the current state of affairs. Another approach may be to provide some

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type of loan forgiveness to practitioners who agree to remain in the area for a set period, similar to the National Health Service program. An additional approach may be to raise Medicaid reimbursement, particularly for gynecologic care within the Western Massachusetts area. Providing a means for a better reimbursing for nutritional and social services would also help those who serve individuals with high needs in these areas. My laser suggestion is to consider improving the reimbursement for mid-level practitioners. For example, Nurse Practitioners and Certified Nurse Midwives, are reimbursed 15% lower than physicians in many instances for the same level of services. By increasing their reimbursement, it would allow some practices to make use of such practitioners when physicians can not be recruited.

Again, I would like to thank the Commission for allowing me to testify. I look forward to any help that you can give the practitioners of obstetrics and gynecology within Western Massachusetts.

Massachusetts Penalty Guidelines for Uninsured

According to penalty guidelines unveiled by the Department of Revenue recently, hundreds of thousands Massachusetts Residents who remain uninsured will face monthly fines that could total as much as $912 for individuals and $1,824 for couples by the end of 2008.

Individuals who failed to sign up for health insurance at the end of 2007 face a one-time loss of their $219 personal income tax exemption. The penalties apply only to adults deemed able to afford health insurance by the Health Insurance Connector Authority, which oversees the health care law. People can apply for hardship appeals.

The fines are part of an increasingly aggressive approach written into the health care law designed to pressure Massachusetts residents into getting insurance. The law, intended to create near-universal coverage in the state, was approved by lawmakers and signed by former Gov. Mitt Romney in 2006.

The penalties, which vary with age and income, are based on half the lowest cost plans available through the Health Care Connector. They accrue each month an individual remains uninsured and will be due as part of tax returns filed early in 2009.

Those overseeing the law say the state shows about 169,000 people who have enrolled in the program by fiscal year ending June 30, 2007 and, the program is expected to reach 342,000 by year 2011. Annual expenses could reach to $1.35 billion. The figures far outstrip the original plans for the Commonwealth Care program, largely because state officials underestimated the number of uninsured residents. Even with federal backing, the state may not be able to afford the insurance initiative as designed, because the law did not attempt to trim wasteful health spending.

Alleviating a Shortage of Physicians in Maine

In February, Maine Medical Center and Tufts University announced a new physician training program that could increase the state's supply of doctors by reserving spots for Mainers and promoting the state as a good place to practice medicine.

The program will start accepting applications this fall for the 2009-2010 school year. Students will spend their first two years taking classes with other Tufts medical students in Boston. They will go to Maine for the final two years to do rotations at Maine Medical in Portland or other hospitals.

With a plan to graduate 36 students a year -- 20 of whom will be from Maine, or have a connection to the state -- program coordinators say it could help alleviate a shortage of doctors being seen around the country.

Maine Medical Center sees it as having a special responsibility to invest in the future of education of physicians, hoping that many will stay in the state.

Maine residents would not have to pay more than what it costs to attend a medical school at a public university. The hope is that a combination of public and private dollars will cut the $50,000-plus yearly tuition for Tufts to less than $25,000.

Tufts is interested in turning out primary care physicians needed in rural Maine. From the 1930s to the early 1980s, federal funding allowed Tufts students to work at Maine hospitals, including Maine Medical. 300 Tuft-educated doctors live in the state, including 60 on staff at Maine Medical. The partnership between Tufts and Maine Medical represents a departure from the typical relationship between medical schools and teaching hospitals.

When students graduate, they will receive a combined degree from Maine Medical and Tufts. Hospital officials say the program jointly offered by the Cleveland Clinic and Case Western University is the only one they know of that also grants a combined diploma.

The program is expected to help Maine physicians who have trouble attracting and keeping physicians because of the low Medicare payments and, will help alleviate a shortage of physicians in Maine.

Maine Medicals affiliation with the University Of Vermont College Of Medicine will end in 2011, to make room for the Tufts students.

FIFTY-YEAR MEMBERS
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JOHN P. SULLIVAN, M.D.
WILLIAM W. WALTHALL, JR. M.D.
ALAN ZISKIND, M.D.

The Fifty-Year Members will receive their Award at the Annual Meeting.

WELCOME NEW MEMBERS

Administration

Thomas Ebert, HNE
One Monarch Place, Ste. 1500, Springfield
Anesthesiology
Abhijit Desai, Anesthesia Associate of Springfield
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Leslie Dubinsky, Wing Memorial Hospital
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Pranay Kanake, BMC Dept of Anesthesia
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Richard Lofrumento, Noble Hospital
115 West Silver St., Westfield
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Jason Port, Diagnostic Radiology
MRI Center. 3640 Main St., Ste. 101, Springfield

Urology

Phillip Kick, Urology Group of W. N. E.

Resident/Fellow

Berkshire Medical Center

Thomas Graziano - Surgery

Baystate Medical Center

Tarayn Fairlie – Pediatrics
Cyrus Khan – Internal Medicine
Aalya Ramadhan – Internal Medicine
Elema Ziarnik – Surgery
Le Grand Reynolds - Emergency Medicine
Christopher Chapman – Pathology
Gabriel Caponetti – Pathology
Melissa Hull – Surgery
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Ellen Lorange – OB/Gyn
Brett Murphy – Emergency Medicine
Fadi Saab – Cardiology (Fellow)
Kathryn Sharpless – OB/Gyn
Richita Tiwari – Pediatric Endocrinology
Jennifer Toone – Emergency Medicine
Adrienne Yarnish – Emergency Medicine
Timothy Abbott - Anesthesiology
Rebecca Abell – Pediatrics
Sailaga Alapati – Anesthesiology
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Amir Bernaba – Emergency Medicine
Myrvine Bernadotte – Emergency Medicine
Viviane Bunin – Internal Medicine
Selin Caglar – Internal Medicine
Mariana Cajaiba – Pathology
Sandra Camelo-Piragua – Pathology
Daniel Case – Radiology
Dana Cerone – Emergency Medicine
Astrid Chabert – Pediatrics
Eun Chang – Surgery
Sonia Chaudry – Pediatrics
Zulfiqar Chaudhry – Internal Medicine
Nathan Conway – Surgery
Jacquelyn Cotter – Pediatrics
Abbie Courtemanche – Internal Medicine
Brian Crowley – Emergency Medicine
Jiang Cui – Cardiology
Robert DeFlorio – Radiology
Carolyn Delk – OB/Gyn
Rbecca DiCampli - Anesthesiology
Adriana Doldan – Pathology
Mohamed Elarabi – Internal Medicine
Itoro-Obong Elijah – Surgery
Dasia Esener – Emergency Medicine
Katharine Ewall – Med/Peds
Suzette Fink – Emergency Medicine
Adrian Fluture – Interventional Cardiology
Laura Forman – Emergency Medicine
Amy Francis – Internal Medicine
Jimmy Fune – Internal Medicine
Debra Gargiulo – Surgery
Elise Gates – Surgery
Kevin Gentile – Emergency Medicine
Anil George – Interventional Cardiology
Linda George – Pediatrics
Arel Golombeck – Radiology
Thomas Gorman – Emergency Medicine
Nita Grover – Pain Management Fellowship
Fei Gu – Internal Medicine
Claudine Habib – Pathology
Jodie Hermann – Internal Medicine
Jose Hernandez Ford – Surgery
James Herrin – Emergency Medicine
Jamie Hess – Emergency Medicine
Lena Heung – Med/Peds
Monca Hollowell – Pathology
Daniel Hseuh – Anesthesiology
Chumei Huang – Internal Medicine
Syed Hussain – Internal Medicine
Dmitri Iarikov – Infectious Disease
Azad Jabiev – Surgery
Jackey Jacob – Med/Peds
Mark Jankowske – Med/Peds
Tracy Jonkman – Emergency Medicine
Jeyavarna Karthikeyan – Internal Medicine
Laura Kester – Pediatrics
Paryssa Khadem – Radiology
Murdoc Khaleghi – Emergency Medicine
Sunah Kim – Pediatrics
Andrew King - Anesthesiology
Shamini Kirupananthan – OB/Gyn
Aseem Kumar - Anesthesiology
Rajesh Kumar – Nephrology Fellowship
Claudia Lago-Toro – Surgery
Julius Larioza – Infectious Disease
Anh Le – Med/Peds
Despina Lekakis – Pediatrics
Scott Lemme – Pediatrics
Albert Lim - Anesthesiology
Kristin Liptock – Hematology/Oncology
Bevan Londergan – Internal Medicine
Brian Lyngaas – Emergency Medicine
David Lynn – Surgery
Ashish Malik - Anesthesiology

WELCOME NEW MEMBERS

Yorell Manon-Matos – Surgery
Lisa Mark – Minimally Invasive Surgery
Elizabeth Martin – Pediatrics
Michelle Mckenney – OB/Gyn
Maureen McNeely - Anesthesiology
Sanjana Mehrotra – Pathology
Jessica Mendivil – Pediatrics
Juliana Meyer – Surgery
Scot Millay – Emergency Medicine
Meena Moorthy – Internal Medicine
Miguel Mujica-Baella – Internal Medicine
Eliah Munyikwa – Nephrology Fellowship
Brett Murphy – Emergency Medicine
Raj Naidoo – Internal Medicine
Danae Netteburg – OB/Gyn
Olen Netteburg – Emergency Medicine
Patrick O'Donnell – Pathology
Obiajulu Okafor – OB/Gyn
Philip Omotosho – Surgery
Ashley Nelson – Med/Peds
Eric Padua – Emergency Medicine
Srinivas Paidy – Radiology
Kavitha Parithivel – Radiology
Gerald Park - Anesthesiology
Ayesha Parvez – Endocrinology
Hetal Patel – Radiology
Niva Patel - Anesthesiology
Edward Patriquin – OB/Gyn
Amy Pelletier – Pediatrics
Yalonda Phillips – Emergency Medicine
Jeffrey Pinco – Cytopathology
Brian Prystowsky – Pediatrics
Dana Quarles – OB/Gyn
Peter Quinby – Emergency Medicine
Prithviraj Rai – Interventional Cardiology
Gonzalo Reyes – Emergency Medicine
Daniel Richman - Anesthesiology
Walter Rivera – Pathology
Hilda Rivera-Rivera – Internal Medicine
Lisa Romagnoli – OB/Gyn
Alvaro Rosales – Geriatrics
Frida Rosenblum – Pathology
Thomas Roshek – Surgery
Connie Rossini – Surgery
Geoffrey Sakellis – Radiology
Pragathi Saligram – Internal Medicine
Rafael Sanchez-Yriarte – Med/Peds
Huma Sayed - Anesthesiology
Malinda Scherpa – Pediatrics
Matthew Schreiber – Emergency Medicine
Adrianne Seiler – Internal Medicine
Mayu Sekiguchi – Internal Medicine
Prabhdeep Sethi – Cardiology
Jessica Sexton – Pediatrics
James Sheehy – Pediatrics
Senthil Sivalingam – Internal Medicine
Like Skylizard – Surgery
Andrew Small – Emergency Medicine
Jeremy Smith – Emergency Medicine
Adam Snavely - Anesthesiology
Myron St. Louis – Surgery
Hemaluck Suwatanapongched – Pediatrics
Hannah Swayze – Surgery
Dyanne Tappin – OB/Gyn
Elena Tunitsky Bitton – OB/Gyn
Godfrey Tutay – Peds Emergency Medicine
Erica Tyler – Radiology
Betsy Valade – Pediatrics
Gregory Valania – Cardiology
Neelima Vallurupalli – Cardiology Fellowship
Aimee Velasco – Pediatrics
Erez Vidan – Radiology
Heather Walsh – Emergency Medicine
Joshua Walterscheid – Emergency Medicine
Kathleen Wang – OB/Gyn
Siddharth Wartak – Internal Medicine
Thomas Wigginton – Radiology
Hagen Yang – Internal Medicine
Karin Zuegge - Anesthesiology
Michael Zur – Pathology

Student

Elizabeth Dibble – Boston University, Class of 2011

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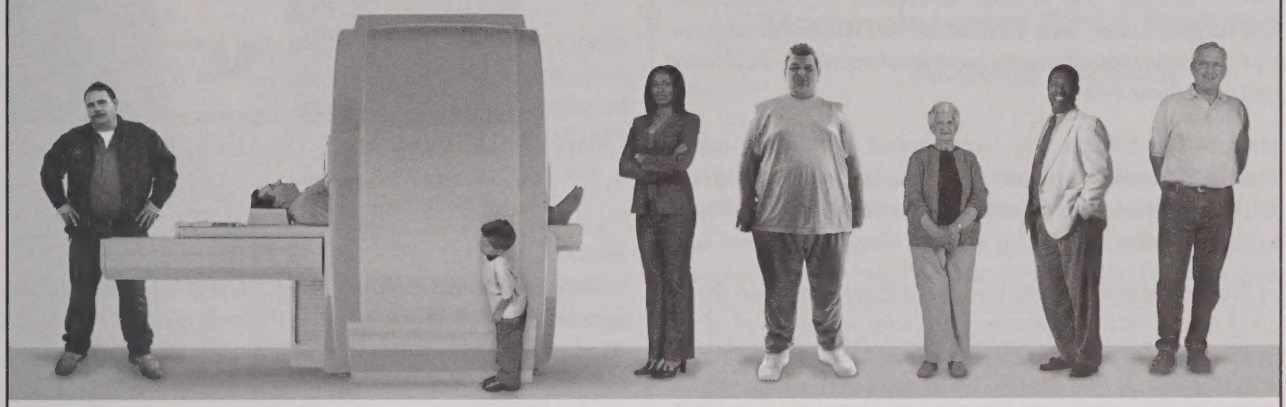

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23rd ANNUAL MEDICAL ETHICS SEMINAR

Utilization of the ED and lack of services for mentally ill and substance abuse patients became the focus of the Hampden District Medical Society's 23rd Annual Medical Ethics Seminar; Ethical Practice When There's Not Enough: A Healthcare in Crisis. The Seminar was held on October 21, 2007 at Mercy Medical Center.

The goal of the seminar was to raise awareness of the medical, ethical and community issues of a Healthcare in Crisis and address the immense problem of mental health issues and mentally ill clients in the emergency medical system.

Medical staff in the Emergency Department is treating more substance abuse and mentally ill patients and, they tend to spend longer in ERs than patients with other conditions and can contribute to delays for other patients.

Hospitals in Western Massachusetts have been known to report that a mentally ill child may sit in the emergency room for seven days before they could locate a bed or, send the patient home.

"Understanding of the Legislative Process and How One Can Help Support a Legislative Mental Health Agenda", was Representative Kay Khan's Keynote Address.

Rep. Kahn & Senator Gale Candaras

In 1998, Rep. Khan founded and continues as Co-Chair of the Legislative Mental Health Caucus. The Caucus, which includes over 80 Legislators, has spurred greater attention to the need for improved mental health services thus creating the new legislative Mental Health and Substance Abuse Committee in the Commonwealth.

Rep. Kahn, a practicing psychiatric nurse is a clinical specialist certified in psychiatric mental health and licensed to practice in the expanded role by the Commonwealth of Massachusetts. She holds a professional staff appointment at Newton-Wellesley Hospital.

John Auerbach, Commissioner of the Massachusetts Dept of Public Health a guest speaker, informed the participants what the Department of Public Health is doing regarding the crisis.

As Commissioner, he heads a Department with 3,100 employees that includes four public health hospitals, the State Laboratory, several regulatory bodies, and numerous programmatic units addressing chronic and infectious disease, substance abuse, environmental health, tobacco control, children and adolescent health and emergency preparedness.

Prior to his appointment Commissioner Auerbach was the Executive Director of the Boston Public Health Commission where he oversaw the City's Emergency Medical Services Department, several substance abuse treatment facilities and the second largest homeless services program in New England.

Chief of Staff, Veronica Valdes Lupi, accompanied Commissioner Auerbach.

MA Department of Public Health Chief of Staff Veronica Lupi, Commisioner Bruce Auerbach, Panelist Dr. Jill Griffin, Dr. Karen Ferroni

Panelist, Dr. Jill Griffin is Board Certified in Emergency Medicine and is Medical Director of the Emergency Department at Mercy Medical Center.

Dr. Griffin who has written numerous articles and presented scientific lectures at national meetings, and submitted several bibliographical research papers also serves as Assistant Professor of Emergency Medicine at Tufts University School of Medicine.

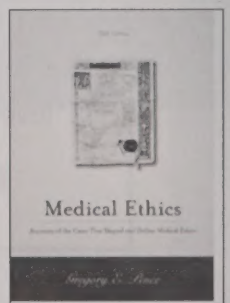
Dr. Griffin's slide presentation, "An Overview of the Utilization of Emergency Departments: The Crisis in Emergency Medicine", reviewed the Emergency Medical Treatment and Active Labor Act and, showed the data of patients presenting psychiatric issues, substance abuse visits and average length of stays in the ED. Dr. Griffin also touched on the ethical challenges i.e.: who "deserves" the bed, the medical patient with a stroke or the psych patient with no other options.

Summing up her presentation, Dr. Griffin informed that participants that there seems to be some hope for providers and thinks that everyone is committed to the cause, and feels that nowadays there is better training for staff.

Panelist Robert Azeez, a certified counselor in rehabilitation and a licensed counselor in advanced status in alcohol and drug addiction is Clinical Supervisor at Baystate Medical Center's Carlson Recovery Center.

Mr. Azeez's job consists of supervising the Detox Center, counseling the staff and implements policies and procedures along with managing caseloads.

Mr. Azeez presentation, A System in Crisis: The Substance Abuse System, Where it is Today and Where it was Yesterday reflected on what the major problem was years ago and what the problem is today which is still, lack of treatment facilities.



Colleen Stocks and Dr. Frank Robinson

"The Failure of the Present System and other Related Issues" was Panelist, Frank Robinson's presentation.

Early in his career, Frank directed the development of local and regional systems operated by the Massachusetts Dept. of Mental Health and the Ohio Dept. of Mental Retardation and Developmental Disabilities.

A public health professional with 20 years of Community Health Education experiences in a variety of public and private agencies is Executive Director of the City of Springfield's Community Partnership.

Colleen Stocks and Dr. Frank Robinson

For the past 10 years, Dr. Robinson is working on a grant for substance abuse prevention and currently oversees a broad public-private partnership that operates under the umbrella of Partners for a Healthier Community that addresses issues such as improving school health services.

Panelist, Colleen Stocks is currently Clinical Supervisor at the Western Massachusetts Correctional and Alcohol Treatment Center. The Center houses 182 residents, 18 women, 164 men and serves, Hampden, Worcester, Franklin Berkshire and Hampshire County.

Colleen presented, "An Overview of Treatment at Western Mass Correctional Treatment Center."

Ms. Stocks informed the participants that the number of people coming into the jail system has quadrupled in terms of needing mental health services in the last six years. Over 50 percent of the people who go through the system need some mental health treatment and that jails are woefully unequipped for the role as community-based services are not available.

The WMCAC seeks to provide a safe, secure and therapeutic environment using an ecological approach to enhance the physical, intellectual, emotional and spiritual growth of the residents.

Ms. Stocks stressed the need for intervention and not punishment and called it painful to see children with severe mental illness incarcerated even when they have committed insignificant offenses, because there is nowhere else to put them.

A "Bill" sponsored by Representative Khan would mandate an interagency review of the mental health and substance abuse needs of teens in the juvenile courts. The Bill would establish a pilot program for assessment of adolescents in Springfield.

Massachusetts Child Psychiatry Access Project

Western Massachusetts physician Dr. Barry Sarvet, chief of child psychiatry at Baystate Health and a Yale-trained child psychiatrist, has been taking calls to offer guidance for three years, as part of the Massachusetts Child Psychiatry Access Project, a program that allows virtually any Massachusetts doctor who treats children to call for an immediate consultation about any patient's mental health -- for free.

The first of its kind in the nation, the program has been ramping up since 2004 and now covers virtually the entire state. Psychiatric specialists in six regional teams offer phone advice within half an hour, face-to-face evaluations within days, and help obtaining mental health services for children and teens.

It also conserves a scarce resource: child psychiatrists. They are in short supply around the country, and waits for appointments can stretch to months. The new project helps primary care physicians handle relatively simple mental health issues, such as moderate depression or anxiety, freeing up the psychiatrists' time for more complex and severe cases.

The project's consultants emphasize that their function is essentially educational, sharing information about state-of-the-art psychiatric practices and standards, and recommended drug dosages. The specialists tend toward highly conservative and circumspect opinions. If they are at all unsure, they ask that the child come in for a face-to-face evaluation and, they do not write prescriptions themselves. (413-536-5111)

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OBITUARIES

DR. EDWARD CARUSO
1917-2008

Dr. Edward Caruso a well- known Pediatrician died on, February 21, 2008. Graduating with empty pockets into a recession, he worked for three years to accumulate cash; first as a night dishwasher, then short order cook and finally as a tool clerk at American Bosch to enter Boston University School of Medicine. Dr. Caruso served on the Pediatric Staff of Mercy Hospital (now Mercy Medical Center), and the staffs of Springfield Wesson Memorial, and Wesson Women's Hospitals, the latter now combined into Baystate Medical Center, where he was the last community based Chief of Pediatrics before the hospital hired a full-time in hospital Chief. He leaves one son and four daughters. In his Obituary, Dr. Caruso wished everyone peace and good lives.

Memorial gifts may be sent to the Perkins Braille & Talking Book Library, 175 North Beacon St., Watertown, MA 02472.

DR. KENNETH M. FRANKEL
1940-2007

Dr. Kenneth M. Frankel died on June 17, 2007.

He was a graduate of Downstate Medical Center in Brooklyn, NY and interned at Yale-New Haven Hospital Dr. Frankel was appointed clinical professor of Cardio Thoracic Surgery at the Tufts School of Medicine at Baystate Medical Center where he also served as Chief of Thoracic Surgery. Dr. Frankel's intellectual and surgical abilities were greatly appreciated within the medical community of Western Massachusetts and was loved and respected by the patients he treated and his nursing and resident associates. He is survived by his wife Felice and his two sons Matthew and Michael.

Memorial contributions can be sent to Baystate Medical Center, "The Dr. Kenneth M. Frankel Fund at the Baystate Health Foundation" 759 Chestnut St., Springfield, MA 01107.

DR. GARRY HOUGH, III
1926-2007
Past President 1982-1983

Dr. Garry Hough, III died in Orange City, Florida on August 17, 2007. Dr. Hough, a past president of the medical society, graduated from Harvard Medical School. He started his orthopedic surgery practice with his father and established Chestnut Orthopedics in Springfield. Before his retirement in 1996, he served as president of the staff at Wesson Memorial, and assistant chief of surgery at Shriner's Hospital. Dr. Hough was also a state representative to the American Medical Association. Dr. Hough's hobbies were golfing and singing. Dr. Hough is survived by: his wife, Nancy; daughters Meta, Alice, Ginny, Hilda and a son Rick. Memorial gifts may be made to Health Volunteers Overseas-Orthopedic Concerns.

DR. SAMUEL R. KLIBANOFF
1916-2007

Dr. Samuel R. Klibanoff died on June 23, 2007.

Dr. Klibanoff was a graduate of Harvard Medical School and, for many years had a medical practice in Springfield. He served as President of Wesson Memorial Hospital. Colleagues said that Dr. Klibanoff will always be remembered for his kindness, compassion and integrity to his family, friends and patients. He is survived by his children, Dr. Alan Klibanoff and daughters Ann and Jeannie.

Donations may be made to Juvenile Diabetes Research Foundation, 20 Walnut St. Suite 318, Wellesley, MA 02481.

DR. RICHARD K. DOUGLAS
1923-2007

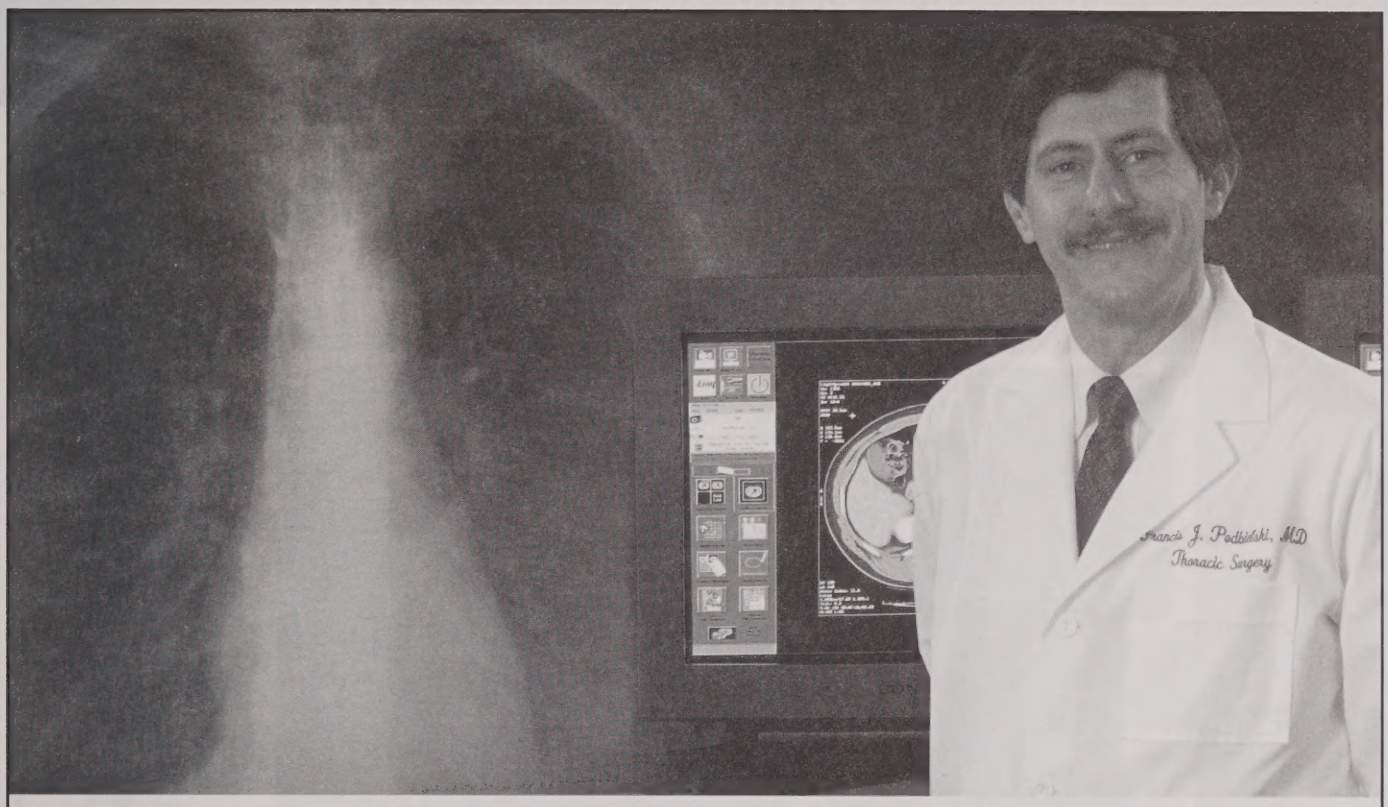
Dr. Richard K. Douglas died on October 17, 2007. He was a graduate of Albany Medical College where he also did his Surgical Residency. Dr. Douglas was a General Surgeon in private practice at The Douglas Clinic in Westfield and was on the Staff of Noble Hospital where he became an honorary member in 2007. Dr. Douglas was President of the Medical Staff, Chief of Surgery, on the Board of Trustees, Medical Director of the Occupational Health Clinic and Women's Health Center at Noble Hospital. Dr. Douglas enjoyed spending his summers sailing coastal New England and was a model train enthusiast. He leaves his wife Maryann.

Donations may be made to The First Congregational Church or Noble VNA & Hospice, 77 Mill St., Westfield, M

WILLIAM F. MCKEON, M.D.
1933-2007

Dr. William McKeon died on December 4, 2007. Dr. McKeon received his medical degree from the New York College of Medicine and a Masters in Public Health from Yale University. He practiced urology for 20 years at William W. Backus Hospital where upon retirement a unit was named for him. After working for many years with Monsanto as medical director he pursed a second career in public health. Dr. McKeon was a talented singer and pursed many other interests such as cooking and playing the piano. He leaves his wife Kathleen and four sons.

Memorial contributions may be sent to Baystate Visiting Nurse Association & Hospice, 50 Maple Street, PO Box 9058, Springfield, 01102-9058



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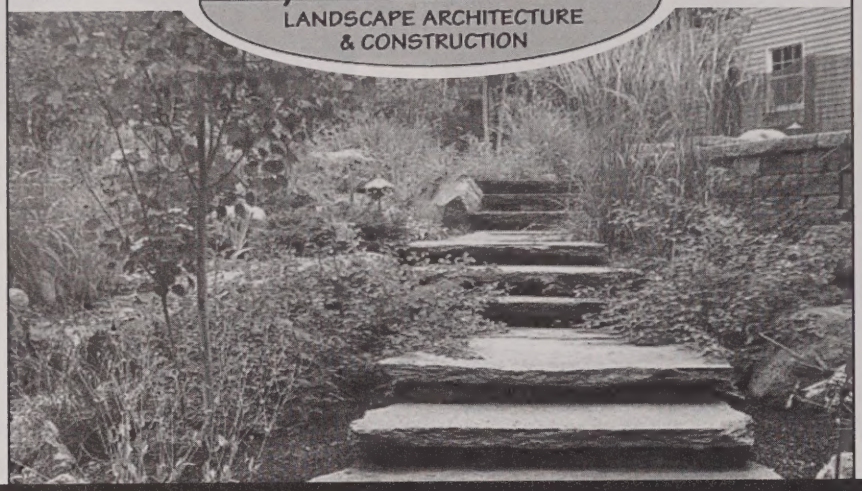

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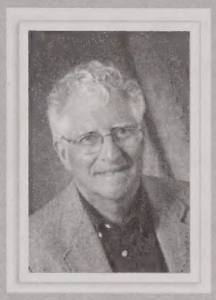
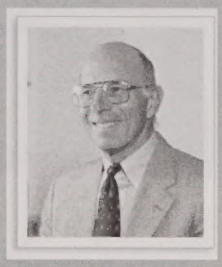


Dr. Richard A. Courtney



Dr. Barry F. Sachs

Dr. Richard A. Courtney and Dr. Barry F. Sachs, pediatric surgeons of Pediatric Surgical Services, Inc of Springfield have been chosen to receive the 2008 Community Clinician of the Year Award.

This annual award is sponsored by the Massachusetts Medical Society and Hampden District Medical Society and recognizes a physician who has made significant contributions to patients and the community. Candidates must be members of the HDMS to qualify.

Drs. Courtney and Sachs will receive their Award at HDMS Annual District Meeting being held on April 29, 2008 at The Log Cabin Banquet & Meeting House in Holyoke.

In addition the award recipients will also be recognized at the Annual MMS House of Delegate Meeting held in May in Boston.

The Society wishes to congratulate Drs. Courtney and Sachs on receiving this prestigious award.

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MEMBERS IN THE NEWS

Dr. Richard Anderson was recently appointed Chief of Surgery at Mercy Medical Center.

Dr. Anderson a busy Neurologist in solo practice in Springfield and Pittsfield is a graduate of the University Of Connecticut School Of Medicine.

Before returning to New England in 1995, he practiced in Florida where he was a member of the Florida Medical Association.

Dr. Andersen has been an active member of the Society for 13 years serving as President 2004-2005 and as a delegate to the Massachusetts Medical Society House of Delegates.

Dr. Scott M. Halista was appointed chief of the Rheumatology Division in the Department of Medicine at Baystate Medical Center. Dr. Halista has been an active clinician-educator for Baystate's residency programs in the Rheumatology Clinic at the High Street Health Center.

Dr. Benjamin Liptzin, chairman of the Department of Psychiatry at Baystate Medical Center, and professor and deputy chair of the Department of Psychiatry at Tufts University School of Medicine, is the lead author of an article titled, "The Future of Psychiatric Services in General Hospitals" October 2007 issue of the American Journal of Psychiatry, the official journal of the American Psychiatric Association.

The Article noted that inadequate insurance payments for services provided by psychiatric units in general hospitals have led to closings, downsizing, or off-campus transfer of inpatient psychiatric units. In addition to better reimbursement by private insurers, the authors' list of proposals includes new revenue sources for departments of psychiatry, as well partnerships between hospitals and community services to ensure efficient psychiatric care.

Dr. Heather Sankey, was one of 20 scholars inducted into the 2007-2008 class of the APGO/SOLVAY Pharmaceuticals Education Scholars Development Program. The Association of Professors of Gynecology selected Dr. Sankey an Obstetrics (APGO) from a competitive nationwide pool of applicants based on her professional credentials and demonstrated commitment to women's health education. Dr. Sankey a past president of the Society is Director of Ob/Gyn Residency Program at Baystate Medical Center.

Dr. Jerry M. Schreibstein a practitioner with Ear, Nose & Throat Associates of Springfield, Inc., has been named chair-elect of the Board of Governors of the American Academy of Otolaryngology—Head and Neck Surgery.

The American Academy of Otolaryngology – Head and Neck Surgery, one of the oldest medical associations in the nation, represents more than 12,000 physicians and allied health professionals who specialize in the treatment of the ears, nose, throat, and related structures of the head and neck. The Board of Governors was established in 1982 as a grassroots member network within the Academy, and is made up of local, state, regional, and national otolaryngology - head and neck surgery societies from around the United States and Canada.

Dr. Schreibstein is also an assistant clinical professor of otolaryngology at Tufts University School of Medicine and is a past president of the Massachusetts Society of Otolaryngology and currently serves as chair of the Socioeconomic and Grassroots Committee of the Academy.

Dr. Winthrop Whitcomb, a long time Hospitalist at Mercy Medical Center, has released a major textbook in the field of hospital medicine.

"Comprehensive Hospital Medicine,", a 1000-page resource designed for hospitalist, residents and medical students, represents the work of a team of nationally known hospitalist-editors from American's most prestigious medical centers.

The book seeks to cover the entire range of clinical and systems issue that a hospitalist or other physician involved in hospital care confronts on a daily basis.

"Comprehensive Hospital Medicine" can be purchased at www.amazon.com or www.barnesandnoble.com

Buyers will receive a computer code by which they can access the text online at no extra cost.

Hampden Doc Makes House Calls

Doctor Making House Call

Twice a week, Dr. Gregg Wolff of Jewish Geriatric Services in Longmeadow makes house calls. His travels take him anywhere from a trailer park to an elegant mansion.

Dr. Wolff treats older patients who have difficulty getting to a doctor's office - and not necessarily because they are disabled and, he is the kind of doctor who, when Hurricane Katrina hit, jumped on a plane to New Orleans as soon as he could.

Dr. Wolff has been at Jewish Geriatric full-time for a year and when not seeing patients you might find Dr. Wolff acting in a local play, most recently playing Mitch Album in "Tuesdays with Morrie" at the Majestic Theatre in West Springfield.

Jewish Geriatrics' Spectrum Home Health and Hospice Care program also has nurses who make house calls.

If your patients need a home visit, please call (413) 567-6213.

Dr. James Wang

Out of Practice

By: James Wang, MD

A few months ago, I left private practice. After nearly seventeen years, I decided to leave the independence of private practice for the structured shelter of a faculty position at a university-affiliated hospital. It was not an easy decision. In fact, I think it is one of the most serious and difficult decisions of my life. After making several dozen lists of pros and cons of staying or going, I decided to go.

So, why did I decide to leave a rewarding and successful practice, a trustworthy and magnanimous partner, and a dedicated and enviable office staff? As with all complex issues, there is not one or even a few simple answers. If I had to sum it up in a single word, it would be "fear". I fear what I know. I fear what I do not know. I fear for the future of medicine.

I know private practices, especially smaller groups, are under tremendous pressure to change.

Federal legislative mandate to use electronic medical records (EMR) is being debated, and pressure from multiple fronts including CMA, insurance carriers, and patient advocacy groups for EMR is escalating. Those offices that have not already adopted EMR (which are the majority of practices in the U.S.) are facing extraordinary costs – both in finance and time – when they buy a system.

In March 2007, the Congressional Research Service estimated that per-physician startup cost for an EMR ranges from $16,000 to $36,000. Following purchase, yearly costs in licenses, maintenance, software and hardware upgrades are about $8,500 per year per physician according to a study published in a 2005 edition of Health Affairs. In starting up an EMR system, many vendors recommend a 50% reduction in patient visits for two to three months. Offices with long appointment waits and their patients will certainly feel the pain of the learning curve.

Hope that EMR may improve patient care and office efficiency, should not be held high. A study published in the July 2007 Archives of Internal Medicine evaluated 50,000 patient records and showed there was no statistical difference between docs using pen and paper and those using EMR in 14 of 17 guideline-based quality measures. Overall, there was no improvement in quality between the two modalities. The authors, proponents of EMR, were surprised by the findings.

Economic benefits of EMR through increased efficiency in patient care and billing may be limited. Several years ago, in one geographic area of the Northeast, the majority of medical practices converted to EMR. Due to more efficient E/M coding, there was a dramatic increase in level 4 office visits (though the care rendered was the same) throughout the region. Practitioners, expecting improvements in practice income, were sorely disappointed when insurance carriers decided to equalize reimbursement for level 4 visits to those of level 3 visits for cost control measures. The anticipated financial recoupment for the cost of EMR disappeared.

I know there are economic disasters falling upon our profession. Physician tiering is the new rage among insurers. GIC, the state insurance plan, instituted tiering with a nebulous and unfair system. Criteria for determining physicians' tier were unclear. Physicians, rather than groups were tiered individually, potentially pitting partners against each other for patients. If there was insufficient data on an individual physician, he/she was allocated to the higher tier by default – indicating an assumption that the individual was not "as good".

This system of calculating reimbursement by "efficiency" has led physician organizations to spend many hours and dollars to combat implementation of unfair tiering systems. Problems still exist, and patients receive letters implying that physicians on higher tiers are not as good as those on the lower.

I know there is an inordinate amount of work for physicians working in private practices.

Nearly three-quarters of physicians found managing the business of medicine and patient care to be challenging or very challenging according to a 2005 survey by American Express. Nearly half of the physicians surveyed reported spending the equivalent of one day per week managing the business aspect of their practices. Specialists tended to spend more time in practice management. Approximately 20% of urologists, oncologists, and rheumatologists spent more than 21 hours per week on business.

The work does not reflect the rewards. Sixty one percent of physicians noted an increase in patient volume compared to the previous year. However, only 36% had an increase in salary, 34% had no change, and 31% had a decrease in salary. I know these are not encouraging statistics.

I know there is a new generation of physicians coming into our profession trained in modern technology. I know that what medical students and residents are taught –scientifically, clinically, and interpersonally will determine the care that my family and I will receive when I am older.

I do not know why there is not a better understanding of medicine's tenuous position. There is no Band-aide that can "make it all better" as it appears we are being led to believe.

Massachusetts' Commonwealth Connector, the plan to insure the uninsured, was paraded as a model in healthcare reform. However, the new system is already in financial strife. As I predicted at its inception, there just is not enough money to go around. Recent news articles say that the number of uninsured people used to calculate the budget was too low. It is interesting that a correct estimate did exist, but it was not used. I suspect it was a conscious decision to make the program look better than it is.

Now, officials are contemplating reducing reimbursements to… physicians and hospitals. What a surprise.

I do not know why physicians' ability to care for patients continues to erode and patients have an increasingly difficult time accessing healthcare. It is shockingly difficult to find a primary care who is

accepting new patients. Wait times for appointments are sometimes months. There is a critical shortage of Ob/Gyn's in far western Massachusetts.

I do not know if we can change the momentum of the destruction of our medical system and profession. Our actions are more reactionary that proactive. We too often accept the inevitability of change that is not always good for the patient or our profession. We are in a position only to help direct the means of our demise rather than to orchestrate the survival of the integrity of our profession.

So, why did I change? I do not need to try to direct the success of a private practice. Granted, I still need to look at the marketplace and offer suggestions to improve both patient care and office success, but it is under the umbrella of an integrated system. I do not have to bring the business of business of home.

I feel that my current position as faculty will allow me to spend more time on the broader issues of medicine, not solely on my patients and business. I have more opportunities to focus my energy on getting more involved in healthcare policy. Hopefully directing change that makes sense for our patients.

I have the ability to devote more time to teaching. I hope I can encourage some of the traditional skills of medicine that I learned from my parents – both "country doctors". The skills of patience, understanding, and compassion. Sometimes, as much can be learned by studying the demeanor, words, and spirit of a patient as can be by looking at her CT scan.

My move, I hope, will make at least a small difference so that fewer of us will be forced out of practice.

Doctor Ratings Revised

Several health-insurance companies have recently agreed to improve their existing or planned ratings of physicians.

Ratings by some insurers have come under fire for giving top scores to doctors who cost the least -- but who are not necessarily the best in quality or the ones handling the most complex cases. In some plans, there are financial incentives for members to pick high-scoring doctors for their care.

Over the next year, the rankings will become more transparent and thorough under agreements reached in recent months between several of the biggest health insurers and New York Attorney General Andrew Cuomo. Aetna, Cigna, United Healthcare and Well Point have said they'll apply the agreed-upon approach to their ratings nationwide.

The insurers have agreed to rate quality as well as cost and to use independently accepted criteria -- which might include, for example, measures from the not-for-profit National Committee for Quality Assurance -- instead of just claims data to rate physicians. They also will adjust for risk so that, for example, a doctor is not penalized for handling more complex cases that may result in higher costs and more deaths.

Additionally, doctors will be able to review the data and appeal the decisions.

Insurers' ratings may include information on doctors' education and on whether they follow standards consistent with professional associations such as the American Heart Association or the American College of Obstetricians and Gynecologists.

Sister Caritas Cancer Center

Dr. Catherine Carton has been named Medical Director of the Sister Caritas Cancer Center and Chairperson of the Cancer Program.

The Commission on Cancer (CoC) of the American College of Surgeons has again granted a 3-year approval with commendation to the Cancer Program at Mercy Medical Center.

The CoC is a consortium of professional organizations dedicated to improving survival rates and quality of life for cancer patients through standard-setting, prevention, research, education, and the monitoring of comprehensive, quality care. It was established by the American College of Surgeons in 1922. The ACR awards accreditation to facilities for the achievement of high practice standards based on evaluations by board-certified physicians and medical physicists.

The Patient Impact of Physician Rating Programs

By Jeffrey L. Kaufman, M.D.

The Republican's reporting of the state's physician ranking system ("Doctors question different co-pays," Oct.2007] highlights just how difficult it is to quantify healthcare quality and the unintended consequences that can result even with well-intentioned efforts.

The theory behind these ranking systems is that giving consumers access to transparent data about physicians (and hospitals) will lead to better decisions about health issues, and, ultimately, to reduced health care costs.

Physicians, insurers, policymakers, and patients all agree that transparency is a good thing. In particular, physicians in Western Massachusetts agree that having more information is also good for our patients. We welcome programs that can improve patient care and outcomes.

What is questionable about the Commonwealth's physician ranking program is how it's constructed, how the data are being used and applied, and how the program may affect doctor-patient relationships.

The state Group Insurance Commission's program that was the subject of this paper's report - the Clinical Performance Improvement initiative - asks that doctors be ranked in "tiers," based on an evaluation of administrative claims data provided by health insurers. Physicians placed in higher tiers are purportedly less efficient and costlier; therefore, patients who see higher-tiered physicians pay higher co-payments.

Physicians in Hampden County believe the system has serious flaws. The data are several years old. In most cases, physicians are not allowed to check and correct their information before it is publicly released. Patients and procedures are frequently attributed to the wrong physicians. Further, because the methods being used by the health plans vary so much, it is not uncommon for the same physician, rated with the same information, to be ranked in different tiers by different plans.

The unintended consequences of such a program are serious. Physicians can be rated unfairly, and costs can be unfairly shifted to patients, since they can pay more to see doctors mistakenly put into the wrong tier.

(continued from previous page)

It is no surprise that employers, straining under the soaring costs of health care, support programs that may contain costs. All parties, physicians included, support that goal.

A reasoned approach has been put forth by New York Attorney General Andrew Cuomo, whose office in late October reached an agreement with CIGNA HealthCare to revise its physician ranking system. Mr. Cuomo had previously told the insurers to halt such programs, because, as presently constructed, they could be considered deceptive and confusing to consumers.

This agreement calls for health plans to ensure that rankings are not based solely on cost data; to use national standards to measure quality, including risk adjustments and valid sampling techniques; to disclose to consumers and physicians how the program is designed and how doctors are ranked; to provide ways for consumers to register complaints and for doctors to appeal incorrect ratings; to let doctors see and correct any erroneous data before it's made public; and to subject the program to independent oversight.

These are steps in the right direction. Aside from the issue of fairness in rating physicians, this current rating system has serious implications for patients. They should be able to trust that the information about physicians that they're getting from their health plans is accurate and valid. We agree with Mr. Cuomo: "The goal of transparency is defeated," he said, "if the information provided is itself inaccurate or misleading or based on flawed data."

The Massachusetts Medical Society and the Hampden District Medical Society have recommended that similar changes be made to the rating system in the Commonwealth. We urge these be adopted, for the benefit of patients and physicians. The Commonwealth is already coping with severe shortages of doctors in many specialties, especially here in Western Massachusetts. The state should not continue a flawed program that may aggravate the retention and recruitment of physicians and thus further erode patient care.

The goals of controlling costs and improving quality are those everyone in health care seeks to attain. We invite health plans, businesses, and patients to work with physicians to achieve them.

MEDICAL LEGAL FORUM

Members & Attorneys

The 14th Annual Medical Legal Forum for physicians and attorneys was held on November 15, 2007 at The Delaney House in Holyoke.

Drs. Kaufman and Mary Kraft

The Medico-Legal Committee which was created 15 years ago in Hampden County between Hampden District Medical Society and the Hampden County Bar Association was the first of its kind in Massachusetts and a national prototype was developed.

The Title of the Forum, Medical Malpractice: A View from the Bench was selected so participants would better understand the Medical Malpractice Tribunal process, to learn the nuance and finer points of the courtroom experience during a malpractice trial and, to learn from the perspective of experienced malpractice case judges, things that will benefit a physician if they faced their own lawsuit.

Panel members Honorable Judge Constance Sweeney, Daniel Ford and Cornelius J. Moriarty, II

The Panelist informed the participants that it's important that a plaintiff's medical malpractice lawyer screen cases and accept only those that are worthwhile. (In some states, the lawyer must certify that he has reviewed the matter with a qualified physician who states that the case is "meritorious.") Often the experienced lawyer can tell if the case is worthwhile from the first contact with the client. If it is not, the client should be informed immediately and, understand that the legal and medical systems should not be cluttered with the prosecution of worthless cases.

True medical malpractice consists of negligent conduct that causes damage. There may be "malpractice" from a theoretical point of view, but if the conduct has not caused injury, it is not a matter for the legal system. Sometimes there may be true "malpractice" but no residual damage. Juries are not all interested in a past history of damage; they do become interested when a plaintiff can show permanent injury.

Drs. Robert Bryne and Shantilal Kenia

Attorney Joanne & John McCarthy

Physician Guidelines for Testifying in Court as an Expert Witness

Physicians understand that they have an obligation to testify in court as expert witnesses on behalf of the plaintiff or defendant as appropriate.

The physician who acts as an expert witness is one of the most important figures in malpractice litigation.

Recommended qualifications for the physician who acts as an expert witness:

- The physician expert witness must have had a current valid, and unrestricted state license to practice medicine at the time of the alleged occurrence.
- The physician expert witness should have been a diplomat of a specialty board recognized by the American Board of Medical Specialties at the time of the alleged occurrence and should be qualified by experience of demonstrated competence in the subject of the case.
- The specialty of the physician expert witness should be appropriate to the subject matter in the case.
- The physician expert witness who provides testimony for a plaintiff or a defendant in a case involving a specific surgical procedure (or procedures) should have held, at the time of the alleged occurrence, privileges to perform those same or similar procedures in a hospital accredited by The Joint Commission or the American Osteopathic Association.
- The physician expert witness should be familiar with the standard of care provided at the time of the alleged occurrence and should have been actively involved in the clinical practice of the specialty or the subject matter of the case at the time of the alleged occurrence.
- The physician expert witness should be able to demonstrate evidence of continuing medical education relevant to the specialty or the subject matter of the case.
- The physician expert witness should be prepared to document the percentage of time that is involved in serving as an expert witness. In addition, the physician expert witness should be willing to disclose the amount of fees or compensation obtained for such activities and the total number of times he or she has testified for the plaintiff or defendant.

Recommended guidelines for behavior of the physician acting as an expert witness:

- Physicians have an obligation to testify in court as expert witnesses when appropriate. Physician expert witnesses are expected to be impartial and should not adopt a position as an advocate or partisan in the legal proceedings.
- The physician expert witness should review all the relevant medical information in the case and testify to its content fairly, honestly, and in a balanced manner. In addition, the physician expert witness may be called upon to draw an inference or an opinion based on the facts of the case. In doing so, the physician expert witness should apply the same standards of fairness and honesty.
- The physician expert witness should be prepared to distinguish between actual negligence (substandard medical care that results in harm) and an unfortunate medical outcome (recognized complications occurring as a result of medical uncertainty).
- The physician expert witness should review the standards of practice prevailing at the time and under the circumstances of the alleged occurrence.
- The physician expert witness should be prepared to state the basis of his or her testimony or opinion and whether it is based on personal experience, specific clinical references, evidence-based guidelines, or a generally accepted opinion in the specialty. The physician expert witness should be prepared to discuss important alternate methods and views.
- Compensation of the physician expert witness should be reasonable and commensurate with the time and effort given to preparing for deposition and court appearance. It is unethical for a physician expert witness to link compensation to the outcome of a case.
- The physician expert witness is ethically and legally obligated to tell the truth. Transcripts of depositions and courtroom testimony are public records and subject to independent peer reviews. Moreover, the physician expert witness should willingly provide transcripts and other documents pertaining to the expert testimony to independent peer review if requested by this or her professional organization. The physician expert witness should be aware that failure to provide truthful testimony exposes the physician expert witness to criminal prosecution for perjury, civil suits for negligence, and revocation or suspension of his or her professional license.

Who Will Care for Your Minor Children if You Can't?

By: Todd C. Ratner, Esq.

Deciding who will care for your minor children if something happens to you is a tough decision in any circumstance, but it is a decision that you are most qualified to make in your lifetime. Without proper planning, your wishes might not be followed later.

Consider the following scenario. Michael and Alice are a young married couple living in Springfield with two small children. Michael has two sisters, one in Springfield and the other fifty miles away. Alice has one brother in Springfield. Michael's parents reside in another state and Alice's parents live in Springfield. Each set of grandparents are in their seventies.

Michael and Alice did not feel that it was necessary to prepare estate-planning documents because the only real asset that they owned was a house, which had very little equity. Unfortunately, Michael and Alice were involved in an automobile accident that killed both of them.

Now, someone must decide who the guardian of their minor children becomes. Should it be Michael's unmarried sister who lives in Springfield or Alice's brother and his wife who reside in Springfield but are having marital problems? Should it be Michael's other sister who lives in a different city but whom Michael and Alice have always felt closest to? How about either set of grandparents who provide love and support and have experience in raising children?

In most cases, if you die leaving minor children, the other parent will raise and support them. Similarly, in the case of a divorce, when a custodial parent dies, the non-custodial parent has priority in seeking guardianship and custody unless unfit. However, if the other parent is also deceased, your minor children will require a guardian. This is an individual who is appointed by the court to look after the direct physical well-being of your minor children and the assets of the estate left to them. Generally, the guardian provides whatever care would be given to children by their parents.

It is highly recommended that you assume the responsibility for this important decision, rather than leaving it to a judge who is unfamiliar with your family situation. Even though the court has the ultimate authority to appoint a guardian, your Will is the only way to convey to the court who you want to raise your children.

Designating a guardian in your Will does not only help guide the court; it also helps prevent family arguments over who is better qualified. Technically, your choice as guardian is just a recommendation to the court. However, the Commonwealth of Massachusetts gives high priority to your recommendation. Typically, the court will honor your choice unless there is compelling evidence against your designee.

It should be noted that in Massachusetts, a minor over the age of fourteen may suggest his or her own guardian, and the court will try to honor that request if appropriate.

Prior to designating a guardian in your Will, you should ask the person or people if they are willing to undertake this significant responsibility. A guardian is not legally obligated to serve, and an alternative is highly recommended in the event that your first choice refuses or is unable to serve. You also need to consider whether you want to name a person's spouse as co-guardian, as a future divorce could greatly complicate the matter. Therefore, it is recommended that you just name one person.

In selecting the right guardian for your children, following are some factors to consider:

- Where are the proposed guardians geographically located?
- Which proposed guardians most closely match your parenting philosophy?
- Do you prefer that the proposed guardians are a married couple or an individual?
- What is the age and health of the proposed guardians?

In Massachusetts, guardianship ends at eighteen. At this time, they are considered to have full legal capacity. This means that they can make all legal decisions unless there is some factor that legally prohibits them from doing so.

At that point, forward, any property left to a child is exclusively owned and controlled by that child. Accordingly, it is recommended that a Trust be established for your minor children. By establishing a Trust either inside your Will, called a Testamentary Trust, or a Trust outside of your will, you can condition when and how your minor children will receive your money or other property left to them. For example, you may wish to direct that your minor children receive property in stages like at age 25, 30 and 35, while having access to the funds for their support.

The greatest piece of mind that parents of minor children can have is to select and know who will take care of their children in the event that something happens to them. Scheduling a consultation with an experienced estate-planning attorney is the first step to ensuring that your choice of guardian is appointed.

Todd C. Ratner is an estate planning, business and real estate attorney with the Springfield-based law firm of Bacon Wilson, P.C. 413-781-0560; TRatner@BaconWilson.com

Winter District Meeting

The Dark Side of Peer Review was the title of the Winter District Meeting held on January 22, 2008 at the Clarion Hotel & Conference Center in West Springfield.

The Foundation of Excellence in Healthcare, Inc. cosponsored the CME Program/Risk Management Study program.

(continued from previous page)

Dr. Lawrence Huntoon, Chair of the Association of American Physicians and Surgeons, Committee to Combat Sham Peer Review was the keynote speaker.

Dr. Jeffrey Kaufman, President and Dr. Lawrence Huntoon

The Program highlighted how ethical physicians can help protect themselves from sham peer review, and thus help promote and protect high quality health care for their patients.

The participants learned to define the term, sham peer review, learn the common tactics used in sham peer review and understand the importance of the HCQIA law in sham peer review.

Dr. Huntoon informed the participants how to strategize and protect oneself from sham peer review and to counteract it if it is implemented.

If you have any questions the following websites are available.

- Abuse of the "Disruptive Physician" Clause http://www.jpands.org/vol9no3/huntoon.pdf
- The Psychology of Sham Peer Review http://www.jpands.org/vol12no1/huntoon.pdf
- Sham Peer Review and the Courts http://www.jpands.org/vol11no1/huntoon.pdf
- The Poliner Verdict http://www.jpands.org/vol11lno2/huntoon.pdf

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Budget Grants Physicians Medicaid Rate Increase

Physicians who participate in the state Medicaid program will see an additional $13,500.00 in rate increases beginning in July.

The funds honor the commitment to a 3-year rate increase granted physicians in the 2006 Health Reform Law, and funded in House 2, Governor Patrick's proposed budget for fiscal year 2009.

A total of $270 million has been appropriated in the past two state budgets for Medicaid rate increases for hospitals with 15 percent dedicated to physicians. The FY'09 rate increases will be tied to pay for performance standards for hospitals but not physicians.

Massachusetts Medical Society continues to support the increases in the legislature as the budget progresses. Outside section 33 of the budget contains language under which Primary Care Clinician practices with 100 to 1,000 Medicaid patients may be eligible for additional increases under proposed rewards for adopting electronic medical records, achieving specified clinical benchmarks and reporting certain data. This language is included along with several other programs in a $28 million proposal for use of the Essential Community Provider Trust fund.

The Psychology of Sham Peer Review

As sham peer review has spread across the nation, it has left behind a trail of broken and ruined lives and careers of good physicians. Although each case is unique, there are certain common features underlying the psychology of sham peer review.

Psychology of the Sham Peer Review Process

Sham peer review is a premeditated process that begins long before the actual sham peer review hearings and formal proceedings. It begins in the minds of those who set out to destroy a targeted physician. Improper motives, having nothing to do with furthering quality care, drive the process.

The process of sham peer review frequently involves a progressive series of small attacks leading up to a final formal proceeding designed to end the targeted physician's medical career. Sometimes these trial runs may go unnoticed or seem insignificant to the targeted physician. Meanwhile, the hospital often secretly collects, compiles, and even solicits documentation to be used in the final attack at a later date.

The final attack (formal sham peer review proceeding) is often well planned and well choreographed so as to give the appearance of a legitimate, good-faith peer review action. The appearance of due process and fundamental fairness is given top priority, although substantive due process and fundamental fairness are always lacking in sham peer review.

Psychology of the Attackers

Although there are some cases in which one or a few participants in the sham peer review proceedings are lazy and negligent and simply defer to the leaders of the attack in casting their vote against the targeted physician, in most instances those who participate in the sham proceedings know exactly what is going on.

The psychology of the attackers is a combination of the psychology of bullies and that of the lynch mob. The attacks are typically led by one or a few bullies who have gained positions of power over others and who enjoy exercising and abusing that power to attack and harm the vulnerable. Although there is always some improper motive that precipitates the attack, the attack itself often serves to distract attention from the bully's own underlying shortcomings, deficiencies, insecurities, and cowardice.

Sham peer review is by nature a group effort involving collaboration between unethical hospital administrators and unethical physician attackers. The psychodynamics involve both the excitement of the hunt and the raw power of the lynch mob that often develops a life of its own, leading to actions those individuals would likely not take if acting alone. It is the psychology of predators versus prey. Others are drawn into the group hunt via the same type of macabre attraction that often compels people to turn their heads and gawk as they drive slowly by the car wreck, looking for any sign of mangled or dead bodies.

The power to snuff out the career and livelihood of a fellow physician in the blink of an eye provides a certain pathological satisfaction and excitement for some attackers. To share in the "group hunt" is to share in some of the power and excitement. And the nearly absolute immunity the attackers enjoy under the Health Care Quality Improvement Act (HCQIA) and the doctrine of judicial nonintervention further emboldens and enhances the power of the attackers.

Psychology of the Physician Victim

Facing superior power and numbers, the targeted physician soon understands that he is the prey and the hunt is on. The final attack is often unleashed quite suddenly and with great fury. The resultant shock and awe often causes a sudden loss of energy and a mental numbness that impairs the physician victim's ability to defend himself effectively. This often further excites the predators as the deer stands motionless, caught in the headlights.

Shock and awe is followed quickly by denial and disbelief. This is frequently accompanied by a strong belief that the truth will save the victim and set him free. Meanwhile, the stigma attached to mere allegations of wrongdoing produces an intended isolation of the targeted physician. As a result, the physician victim often shuns contact with colleagues, further assisting the predators in cutting the prey out from the herd in preparation for the kill.

At this stage, alone and isolated, facing almost certain demise, extreme fear sets in. How will the physician provide for his spouse and children? How will he cope with the bills that are mounting up now that the attack has stopped cash flow? How will he survive?

Constantly living in an adrenaline-soaked fight-or-flight state further depletes the victim's energy and is often accompanied by significant depression, complete with severe sleep disturbance (too much or too little), weight loss, and a pervasive feeling of helplessness and hopelessness. The risk of "death by stress" or suicide is very real at this stage.

Anger emerges as the physician victim comes to recognize that the truth and the facts do not matter at all in sham peer review since the proceedings are rigged and the outcome predetermined. The procedural presumption is that the physician is "guilty" and the burden is shifted to the physician to prove his innocence—a burden that the attackers will never allow him to meet. Anger is often accompanied by a consuming desire to hold the attackers accountable for their evil deeds. This not infrequently leads to many years of litigation, further depleting the victim's energy and resources, and consuming the lives of the ruined physician and his family.

Chronic fear and anger often take a heavy toll on the physician's physical and mental well-being and on his relationship with family and others. The resulting downward spiral often leaves the physician devastated, still alive physically, but invisible or "dead" to former colleagues and to the profession of medicine. It is a cold and lonely pit that no one could have envisioned upon entering the profession of medicine.

Psychology of the Enablers

Enablers are those physician bystanders who are aware that the sham peer review attack is taking place, but who stand by and do nothing to object or to stop it. It is the psychology of the herd that stands placidly by while one of its own is cut out from the herd and killed. Enablers are like the timid sheep that huddle close together, keeping their heads down, in the hope and belief that the predator's appetite will be satisfied with the "kill," leaving the rest of the herd to graze in peace.

In many instances, a few vocal physician bystanders may be all that it would take to stop the bully's attack. Expressing objections to individual physicians could also destroy the psychodynamics that impel a lynch mob.

Although bullies who launch vicious attacks against physician colleagues may be beyond redemption, renewal of professional ethics through education, and urging of the physician bystanders to get involved, may help to stop the spread of sham peer review. It may be the only hope.

Unless ethical physicians stand up and object, and hold the unethical physicians accountable for their actions, the spreading moral malignancy of sham peer review will irreparably harm patient safety, medical excellence, and the integrity of the medical profession.

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2008 Senior Volunteer Physician of the Year

Dr. Philip Stoddard with Picture Board of his Travels

Dr. Peter Masso, Assistant Chief of Staff, Shriners Hospital Presenting Dr. Stoddard with his award.

A surprised Dr. Stoddard

This prestigious award is presented to a physician who has demonstrated outstanding dedication and commitment to the medical community in a volunteer capacity. Dr. Stoddard, a past president (1981-82) was nominated for this award based on his substantial contributions performing cleft lip and palate surgery at Shriners Hospital for Children in Springfield.

Aside from treating children in Springfield, Dr. Stoddard has teamed up with Rotaplast, an arm of Rotary International, which was formed in 1992 and during the past eight years has sent 30 teams to Third World countries to help children born with cleft lip and palate.

Dr. Stoddard's travels recently took him and a team of 32 to Tacna, Peru where they screened 135 children and operated on 92 in a six-day period. The team consisted of four plastic surgeons, four anesthesiologists, two pediatricians, six registered nurses and Rotarian volunteers making up the team effort. Surgeries are performed in a hospital undergoing reconstruction from earthquake damage. Local Rotarians arranged all accommodations for the visits and gathered children from surrounding areas for treatment.

The Society wishes to congratulate Dr. Stoddard on receiving this honorable Award.

25 co-workers from Shriners Hospital and friends turned out to see, Dr. Philip Stoddard, a Springfield plastic surgeon receive the 2008 Senior Volunteer Physician of the Year Award.

HDMS Scholarship

Dr. Max Millman

In 1976, shortly after the sudden and unexpected death of Dr. Max Millman, at that time Editor of the Hampden Hippocrate, the Society established the scholarship fund as a tribute to Dr. Millman. Dr. Millman was a prominent Internist and pioneer Cardiologist beloved and respected by his colleagues and patients.

Contributions to the Fund were received from his many friends and colleagues both in the community and in the Hampden District Medical Society.

Mrs. Millman contributed $25,000.00 initially to the Fund with the interest used for the annual scholarships awarded to applicants in medical school from Hampden County. A generous contribution is still being received from Mrs. Geraldine Freedman, Dr. Millman's sister-in-law a resident of Florida.

In this trying time of medicine, now more than ever, we need to promote and encourage dedicated women and men to continue to go into this field so in the future all patients get the healthcare they need.

Each year, the District awards several worthy students with a loan of $2000 each from the Dr. Max & Ida Millman Foundation and over the past 32 years approximately $96,000 has been awarded to Hampden County medical students. The Foundation is listed in the Massachusetts Grant Makers.

Due to the cost of the high burden of medical school debt, the Dr. Max & Ida Millman Foundation Scholarship Fund has a new loan program providing relief of paying back the Scholarship/Loan. The relief only applies when upon completion of medical studies, the recipient returns to Western Massachusetts to practice medicine for 1 year.

If you know of someone who is from Hampden County and already attending medical school or planning on going to medical school and wants to take advantage of the scholarship, please contact Suzanne Skibinski, Executive Director at 736-0661 for an application.

The Society wishes to thank Geraldine Freedman, sister-in-law of Dr. Max Millman for her yearly generous donation.

Dr. Max & Ida Millman Scholarship Loan Recipient

Deborah R. Liptzin, Junior, University of Mass Medical School

Gregory R. Waryasz Sophomore, Tufts University School of Medicine

2007-2008 Scholarship Recipient
HDMS, Medical Student Scholarship

Gregory R. Waryasz, Sophomore, Tufts University School of Medicine

Contributions to the Dr. Max & Ida Millman Foundation Scholarship Fund would be most welcome...
Through your generosity; HDMS will be able to continue helping medical students. Please note that you may donate in Memoriam. Any amount you give will be greatly appreciated.
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West Springfield, MA 01089

Health Advocate: A Company That Fights Insurance Denials

If you patient's are denied a medical necessary procedure and receive a letter from the insurance company saying, "This is your last appeal" have them write one more letter asking if there is anyone else in the company that they need to talk to and still don't receive an approval then it shows that your patient has exhausted all internal options, paving the way for going out-side to litigation or a state board. have them turn to Health Advocate.

The Supreme Court ruled recently that consumers have the right to have health plan disputes reviewed by state boards but most patients are unaware that state boards even exists.

The boards are made up of specialists in the area of medicine under dispute. They review medical literature and records from the case, but rarely call witnesses. A decision should come within 60 days or less, depending on the state-much faster if your patient has an emergency case.

The appeal is either free or costs a nominal filing fee. (In many states. The insurer pays for the review, while in others, the state covers the cost.) Most states give information about the process on their websites.

People who work at companies that have "self-insured" health plans, in which the company directly pays all employees medical costs, aren't eligible to apply to state boards, but they have other protections. The federal government regulates self-insured plans. The other type of employer-sponsored plan is one in which the employer buys health insurance from an insurance company. Federal rules require insurers' in-house appeal boards to give judgments in 30 to 60 days; in urgent cases, within 72 hours.

Medicare hires private insurance companies to process claims. Its rules influence how insurers act even in non-Medicare cases.

It is Only a Matter of Time

Physicians all across the country say they can no longer afford to absorb unbillable costs, primary care doctor are increasingly billing for services that patients have long expected to get gratis: prescription refills, photocopies of medical records, phone consultations, family medical leave forms, medical disability forms, waivers of insurance premiums, waivers for handicapped plates, automotive forms, life insurance premium forms, travel insurance forms, and now, e-mail responses.

The practice, almost unheard of five years ago, has disgruntled some patients and is starting to come to the attention of consumer advocates, who denounce it as one more sign of a broken-down medical system.

"The system is moving further and further away from being a public good to one in which the physicians are mere shopkeepers. How many times can they ring up the register?"

Even many physicians admit being uneasy about what they themselves refer to as "nickel-and-diming." And those who have so far bucked the trend suggest it is only a matter of time before they join the crowd but right now many are not as they don't want to offend their patients.

But, doctors see the practice as a necessary evil in times of increased business costs, flat incomes and declining reimbursement from insurance companies — and the lack of a way to bill those companies for services that don't involve face-to-face patient visits.

In today's climate with so much paperwork involved, doctors feel they can no longer give services for free. It was part of doing business and doctors would absorb the cost but many pediatricians are currently charging $5 for school, camp or athletic participation forms.

These "administrative surcharges" have been officially endorsed by several large medical organizations, including the American Medical Association.

I've Done All Types Of Accounting,

But Working With Doctors
Feels Better

Lisa Patenaude, CPA, Senior Manager, and Jacqueline Pleet, M.D., Holyoke Pediatric Associates

I have specialized in accounting and consulting for medical and dental practices for more than 15 years. I enjoy working with doctors and dentists and their administrative support staffs. I like knowing that the work I do helps my clients strengthen their practices. Helping build stronger practices is the focus of our work in the Health Care Services Division at Meyers Brothers Kalicka. We are keenly aware of the challenges our clients face as they attempt to balance the necessities of running the business side of their practices with their mission: helping people in need of health care. Our job is to make the business part as easy as possible, so our clients can focus their attention on providing quality care to their patients. In addition to accounting and tax services, MBK Health Care Services can assist with managed care contracts, employment contracts, compensation arrangements, buy-in and buyout agreements, practice revenue enhancement, financial management and other practice management matters. We perform practice valuations and facilitate practice mergers, acquisitions, sales and divestitures. We also offer expert consulting in the areas of regulatory compliance and information technology through our network of health care advisors whom we bring on board as needed. As with everyone at MBK, we in Health Care Services, provide personal attention and top-quality service to every client. So when you work with us, you can concentrate on the thing that gives you the greatest satisfaction, healing, knowing our greatest satisfaction comes from helping you keep your practice healthy.

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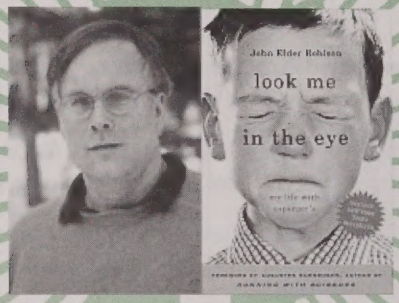
HAMPDEN DISTRICT MEDICAL SOCIETY
ANNUAL DISTRICT MEETING
MEDICAL STAFF and GENERAL PUBLIC INVITED

An Evening with John Elder Robison: Local author of:
Look me in the Eye: My Life with Asperger's

TUESDAY, APRIL 29, 2008



The Log Cabin Banquet & Meeting House
500 Easthampton Road, Holyoke, MA
Registration 6:00-7:00 PM
Dinner: 7:00 PM
****MEMBERS NO CHARGE: NON-MEMBERS $30.00 STUDENTS: $20.00***

2008 COMMUNITY CLINICIAN OF THE YEAR AWARD
DR. RICHARD A COURTNEY & DR. BARRY F. SACHS
PEDIATRIC SURGICAL SERVICES, INC.

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"Gone are the days when caring for our patients was done only in an office or hospital. Today caring means working as a unified group to preserve patients' rights. It means supporting your local and state medical societies. Become involved. Only by working together can we achieve a new day in health care for all patients."